

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF
CLINICAL LABORATORY
SERVICES PROVIDED UNDER
THE KANSAS MEDICAID PROGRAM**



JUNE GIBBS BROWN
Inspector General

OCTOBER 1995
CIN: A-07-95-01147



Region VI I
601 East 12th Street
Room 284A
Kansas City, Missouri 64106

CIN: A-07-95-0 1147

October 17, 1995

Ms.. Rochelle Chronister, Secretary
Kansas Department of Social
and Rehabilitation Services
Docking State Office Building
915 Harrison, Room 603 North
Topeka, Kansas 666 12

Dear Ms. Chronister:

This report provides you with the results of an Office of Inspector General (OIG), Office of Audit Services (OAS) review titled *Clinical Laboratory Services Provided Under The Kansas Medicaid Program*. Our objective was to determine the adequacy of procedures for payment of clinical laboratory claims during calendar years 1993 and 1994. Specifically, we evaluated Kansas (State) Medicaid program claims for chemistry, hematology and urinalysis tests to determine if the tests were appropriately grouped for payment (bundled) and whether payments included duplicate services.

Medicaid providers received excess reimbursement estimated at \$344,254 (Federal share \$202,766) during calendar years 1993 and 1994 for clinical laboratory services that were unbundled (not grouped for payment) or duplicated. The State did not have adequate procedures to prevent paying for unbundled or duplicate laboratory services. We recommend the State (1) install edits to prevent payments for unbundled or duplicate services; (2) instruct providers on bundling requirements; (3) identify and recover 1993 and 1994 overpayments from providers; and (4) return the Federal share of recovered overpayments to the Health Care Financing Administration (HCFA). We estimate that the State could save \$172,127 (Federal share \$101,383) annually or about \$860,635 over a 5-year period by implementing bundling and duplicate edit procedures.

The State did not concur with our findings and recommendations. Specifically, the State responded that Medicaid program rules did not require bundling for many of the clinical laboratory procedures included in our audit. The State response is summarized following the recommendation section of this report along with our comments concerning the State response. The State response is included in its entirety as Appendix E.

INTRODUCTION

BACKGROUND

Medicaid is a federally-aided, state program that provides medical benefits to certain low income persons. Within broad Federal guidelines, HCFA provides general oversight and the states design and administer their individual Medicaid programs. The program, authorized by Title XIX of the Social Security Act, requires states to provide certain medical services and permits them to provide other services, such as outpatient clinical laboratory services used to help diagnose and treat illness. Physician offices, hospital laboratories, or independent laboratories can provide clinical laboratory services.

Federal matching funds are not available to the extent a state pays more for outpatient clinical laboratory tests than the amount Medicare recognizes (State Medicaid Manual (SMM), Sections 6300.1 and 6300.2). The Medicare organizations (carriers) that pay physicians and independent laboratories maintain the fee schedules that are provided to state Medicaid agencies. Medicare reimburses clinical laboratory services at the lower of fee schedule amounts or actual charges. Clinical laboratory services include chemistry, hematology and urinalysis tests.

Reimbursement for chemistry tests frequently performed on automated equipment is limited to panel rates based on grouping individual tests together. Similar restrictions apply regarding organ panel rates, which involve combining chemistry tests under problem-oriented classifications. When testing includes doing all of the component tests, use of organ panel rates limits reimbursements. Many component tests of organ panels are also chemistry panel tests.

Hematology tests are performed and billed in groups or combinations of tests known as profiles of specific hematology tests. However, hematology tests can also be performed individually. Duplicate billings occur when individual hematology tests are billed for the same patient for the same date of service as a hematology profile which includes the individual test. Duplicate billings also occur when two hematology profiles are billed for the same patient and same date of service. Another situation which creates a duplicate billing is hematology indices that are billed with a hematology profile. Indices are measurements and ratios calculated from the results of hematology tests. Since hematology indices are calculated along with the performance of each hematology profile, a separate billing for hematology indices results in a duplicate billing.

Reimbursement for urinalysis tests depends on whether there is physical, chemical or microscopic analysis or just examination of urine. A complete urinalysis includes testing for components and a microscopic examination. However, providers can perform and bill different levels of urinalysis testing including urinalysis with microscopic examination, urinalysis without microscopic examination or microscopic examination only. Based on the test performed and billed, unbundling or duplication of billing can occur.

SCOPE

We conducted our review in accordance with generally accepted government auditing standards. Our objective was to determine the adequacy of procedures for the payment of Medicaid claims involving clinical laboratory tests. Specifically, we reviewed payments for proper groupings and for duplicate services. The audit was limited to clinical laboratory services involving chemistry, hematology, and urinalysis tests listed in Appendix A.

To accomplish our objective, we:

- o reviewed State policies and procedures for payments regarding clinical laboratory services.
- o extracted calendar year (CY) 1993 and 1994 paid claims for clinical laboratory procedures listed in Appendix A from the State's CY 1993 and 1994 Paid Claims files. The extraction identified 42,471 instances of potential unbundling or duplication. Total reimbursement for the 42,471 procedures was \$727,660. We did not assess the accuracy of data in the State's files.
- o selected three random statistical samples of 50 instances each involving chemistry claims, hematology claims, and urinalysis claims. Each instance represented a potential payment error in which the State paid providers for clinical laboratory tests (on behalf of the same recipient on the same date of service) on an individual test basis instead of as part of a group or for duplicate services. The 50 instances were selected from a universe of payments representing claims for more than one panel or for a panel and individual tests for the same recipient on the same date of service by the same provider.
- o reviewed supporting documentation for the 150 randomly selected instances to determine the propriety of the payment.
- o utilized a variable sample appraisal methodology in estimating overpayments for chemistry, hematology and urinalysis tests.

Our review of internal controls was limited to evaluating the claims processing function related to clinical laboratory services. Specifically, we reviewed State policies, procedures and instructions for the billing of clinical laboratory services. We also reviewed State documentation on edits involving the bundling of chemistry, hematology and urinalysis tests. Appendix B contains details on the selection and appraising of our review sample.

We discussed the results of the audit with State officials. In addition, we provided copies of our worksheet analysis for each sample of unbundled and duplicate claims reviewed.

We performed our audit during May and June 1995. During this period, we visited State offices and the offices of EDS (the State's Fiscal Intermediary) in Topeka, Kansas.

RESULTS OF REVIEW

Medicaid providers received an estimated \$344,254 in excess reimbursement during calendar years 1993 and 1994, for chemistry, hematology, and urinalysis tests that were not grouped together for reimbursement or were claimed more than once. The excess reimbursement (which included chemistry tests of \$183,578, hematology tests of \$160,419, and urinalysis tests of \$257) occurred because the State had not established adequate procedures to identify unbundled laboratory service claims and duplicate billings which are not allowed for reimbursement under Medicaid. Implementation of bundling procedures could result in savings of about \$172,127 (Federal share \$101,383) annually or about \$860,635 over a 5-year period.

Medicaid Requirements

Reimbursement for clinical laboratory tests under Medicaid cannot exceed the amount recognized by the Medicare program (Section 6300.2 of the State Medicaid Manual). Medicare requires that the payment for separately billed laboratory tests, which are normally available as part of automated battery tests, should be based on the lesser amount of the battery tests. In addition, Medicare makes providers liable when payment errors are made due to overlapping or duplicate billings.

Chemistry Tests

The State had not issued instructions to providers concerning which chemistry tests to bundle. In addition, the State was not aware that chemistry tests Physician's Current Procedure Terminology (CPT) codes 82550, 82977, and 84478 should be bundled under procedures that were established by the Kansas Medicare Carrier.

As a result, 45 of the 50 instances of unbundled chemistry tests that we reviewed contained overpayments. We estimate the State overpaid providers \$183,578 for unbundled or duplicated chemistry tests during calendar years 1993 and 1994. Appendix C lists the frequency that procedure code combinations occurred for the 45 instances of unbundled services in our sample of 50 that contained overpayments.

Hematology Profiles

For the hematology procedures included in our review, the State was not aware of the reimbursement restrictions established by Medicare. As a result, all 50 instances we reviewed involved hematology profiles that were duplicate charges. We estimate the State overpaid providers \$160,419 for duplicated hematology tests during calendar years 1993 and 1994.

Of the 50 duplicate charges, 49 (98 percent) involved blood indices CPT code 85029 on the same day that blood profiles CPT codes 85023, 85024, 85025 and 85027 were billed. Indices are measurements and ratios calculated from the results of hematology tests. Since hematology indices are calculated along with the performance of each hematology profile, a separate billing for hematology indices results in a duplicate billing. A complete listing of the duplicated procedure combinations is provided in Appendix D.

Urinalysis

For urinalysis procedures included in our review, the State methods were generally adequate to avoid bundling and duplications. However, 7 of 50 instances (14 percent) that we reviewed involved urinalysis tests which were duplicated. The 7 instances involved billings for urinalysis without microscopic examinations CPT codes 8 1002 (non-automated) and 81003 (automated) on the same day. We estimate the State overpaid providers an insignificant \$257 for the duplicated urinalysis tests (CPT codes 8 1002 and 81003) during calendar years 1993 and 1994. In 1995, the State implemented an edit to avoid overpayments involving CPT codes 8 1002 and 81003 on the same day.

RECOMMENDATIONS

We recommend the State:

- (1) Install edits to detect bundling errors and billings which contain duplicative tests. We estimate that the State could save \$172,127 (Federal share \$101,383) annually or about \$860,635 over a 5-year period by implementing bundling and duplicate edit procedures.
- (2) Issue instructions and/or reminders to providers concerning bundling requirements.
- (3) Identify and recover the 1993 and 1994 overpayments to each provider for unbundled clinical laboratory services. Based on our audit, we estimate \$344,254 (Federal share \$202,766) should be recovered for calendar years 1993 and 1994.
- (4) Return the Federal share of the overpayments to HCFA as the overpayments are recovered.

State Response

The State response indicates that Section 6300 of the State Medicaid Manual does not require Medicaid agencies to follow bundling procedures established by Medicare carriers. Instead, the State concludes that Section 6300 requires only that states not pay more than Medicare would pay for individual laboratory procedures. The State bases its opinion on a Section

6300 statement which says “The impact of the Medicare regulations on the Medicaid program is strictly with respect to the amount of payment. The applicable Medicare assignment and billing requirements are not necessarily to be incorporated into the State Medicaid program.”

OIG Comments

In our opinion, Medicaid reimbursement exceeds Medicare reimbursement anytime the sum of the Medicaid reimbursement for unbundled claims exceeds the amount Medicare would reimburse providers for the same procedures under the bundling payment process.

State Response

The State disagreed that procedures 82550, 82977 and 84478 should be bundled because Physician’s CPT books for the audit period did not specifically designate the codes as procedures commonly included in panel tests. Consequently, the State disagreed that 19 of the 45 (42 percent) instances involving chemistry tests required bundling.

OIG Comments

For the 19 instances involving Physician’s CPT codes 82550 and 84478, the Kansas Medicare Carrier has determined that the procedures are frequently performed as part of multichannel tests and have required providers to bundle the tests into applicable Physician’s CPT codes 80002 through 80019. The Medicare Carrier has made this determination from researching common practices of laboratory service providers operating in the State. The Physician’s CPT books show examples of procedures that should be bundled. However, the examples are not all inclusive. In any event, Medicaid reimbursement exceeds Medicare reimbursement anytime the sum of the Medicaid reimbursement for unbundled claims exceeds the amount Medicare would reimburse providers for the same procedures under the bundling payment process. Since Medicare would pay less for the 19 instances due to the Carrier’s bundling rules, Medicaid is also required pay the lesser bundled fee.

State Response

The State disagreed with our findings that hematology tests involving CPT code 85029 on the same day as CPT codes 85023,85024, 85025, and 85027 represented duplicate payments. The State indicated that the Physician’s CPT books defined code 85029 as additional indices which meant that the 85029 procedure was in addition to the indices provided under codes 85023, 85024, 85025 and 85027. Consequently, the State disagreed with our findings that 49 of the 50 hematology instances we reviewed included duplicate payments.

OIG Comments

As pointed out in our report, indices are measurements and ratios calculated from the results of hematology tests. Since hematology indices are calculated along with the performance of

each hematology profile, a separate billing for hematology indices results in a duplicate billing no matter how many indices are calculated. Therefore, any claim involving indices CPT 85029 on the same day as a profile (CPT 85022, 85023, 85024, 85025, or 85027) should be denied. The Kansas Medicare Carrier routinely denies all claims for CPT 85029.

State Response

In responding to our recommendations, the State indicated that it had installed the “GMIS Claim Check” software in 1995 to detect bundling errors and duplicate payments. The State estimated savings of \$32,000 per month using the software. According to the State, OIG studied the GMIS software “a few years ago” and recommended its use to states and Medicare carriers. The State also said that providers were reminded of bundling requirements when the State installed in GMIS software system in 1995. In addition, the State did not believe it would be cost effective to recover overpayments due to the small amount (acknowledged by the State to be about \$77,359), age of the claims (CY 1993 and 1994), and work involved.

OIG Comments

The OIG study the State referenced involved a limited scope audit which did not include bundling of clinical laboratory tests. Instead the review involved bundling of surgery, medicine, and radiology procedures at one Medicare Carrier and one State Agency. In addition, the audit covered claims paid during a 2-week period in April 1990 which was about 3 years prior to the period covered by our audit.

The amount of the overpayment amount (\$77,359) acknowledged by the State is not consistent with the State’s narrative comments. That is, the State disagreed with 42 percent of the \$183,578 we estimated as overpayments for chemistry. This means that the State concurred with 58 percent of our chemistry findings or \$106,475. In addition, the State concurred with our finding regarding urinalysis overpayment of \$257. Consequently, the State concurred that overpayments during 1993 and 1994 were about \$106,732 instead of \$77,359. The State erred by applying 42 percent to our \$183,578 estimate and adding our \$257 urinalysis estimate. In any event, we believe the State should conduct a computer assisted review to identify the feasibility of recovering unbundling overpayments from providers. Based on our sample review, 75 of the 150 (50 percent) potential overpayments were to 6 of the 52 (11.5 percent) providers who were included in our sample.

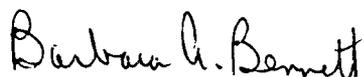
INSTRUCTIONS FOR STATE RESPONSE

Final determinations as to actions to be taken on all matters reported will be made by the HHS action official identified on the following page. We request that you respond to each of the recommendations in this report within 30 days from the date of this report to the HHS action official, presenting any comments or additional information that you believe may have a bearing on final determination.

Page 8 - Ms. Rochelle Chronister

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), OIG, OAS reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.)

Sincerely,



Barbara A. Bennett
Regional Inspector General
for Audit Services, Region VII

Appendixes

HHS Action Official:

Mr. Joe Tilghman, Regional Administrator
Health Care Financing Administration
Richard Bolling Federal Building
Room 235
601 East 12th Street
Kansas City, Missouri 64106

AUTOMATED MULTICHANNEL CHEMISTRY PANEL TEST HCPCS

Chemistry Panel CPT Codes

1 or 2 clinical chemistry automated multichannel test(s)	80002
3 clinical chemistry automated multichannel tests	80003
4 clinical chemistry automated multichannel tests	80004
5 clinical chemistry automated multichannel tests	80005
6 clinical chemistry automated multichannel tests	80006
7 clinical chemistry automated multichannel tests	80007
8 clinical chemistry automated multichannel tests	80008
9 clinical chemistry automated multichannel tests	80009
10 clinical chemistry automated multichannel tests	80010
11 clinical chemistry automated multichannel tests	80011
12 clinical chemistry automated multichannel tests	80012
13- 16 clinical chemistry automated multichannel tests	80016
17- 18 clinical chemistry automated multichannel tests	80018
19 or more clinical chemistry automated multichannel tests	80019
General Health Panel	80050
Hepatic Function Panel	80058

Chemistry Tests Subject to Panelling (35 CPT Codes)

Albumin	82040
Albumin/globulin ratio	84170
Bilirubin Total or Direct	82250
Bilirubin Total and Direct	8225 1
Calcium	82310, 823 15, 82320, 82325
Carbon Dioxide Content	82374
Chloride	8243 5
Cholesterol	82465
Creatinine	82565
Globulin	82942
Glucose	82947
Lactate Dehydrogenase (LDH)	83610, 83615, 83620, 83624
Alkaline Phosphatase	84075, 84078
Phosphorus	84100
Potassium	84132
Total Protein	84155, 84160
Sodium	84295
Aspartate aminotransferase (AST, SGOT)	84450, 84455
Alanine aminotransferase (ALT, SGPT)	84460, 84465
Urea Nitrogen (BUN)	84520
Uric Acid	84550
Triglycerides	84478
Creatinine Phosphokinase (CPK)	82550, 82555
Glutamyltransferase, gamma (GGT)	82977

AUTOMATED HEMATOLOGY PROFILE AND COMPONENT TEST HCPCS

Hematology Component Test CPT Codes

Red Blood Cell Count (RBC) only	85041
White Blood Cell Count (WBC) only	85048
Hemoglobin, (Hgb)	85018
Hematocrit (Hct)	85014
Manual Differential WBC count	85007
Platelet Count (Electronic Technique)	85595

Additional Hematology Component Tests - Indices

Automated Hemogram Indices (one to three)	85029
Automated Hemogram Indices (four or more)	85030

Hematology Profile CPT Codes

Hemogram (RBC, WBC, Hgb, Hct and Indices)	85021
Hemogram and Manual Differential	85022
Hemogram and Platelet and Manual Differential	85023
Hemogram and Platelet and Partial Automated Differential	85024
Hemogram and Platelet and Complete Automated Differential	85025
Hemogram and Platelet	85027

URINALYSIS TESTS

Urinalysis	81000
Urinalysis without microscopy	81002, 81003
Urinalysis microscopic only	81015

SAMPLE METHODOLOGY

At our request, the State's Fiscal Intermediary extracted paid claims from the State's paid claims file for calendar years (CY) 1993 and 1994 for the following laboratory services;

1. automated multichannel chemistry panels and panel tests for chemistry procedure codes listed in the Physician's Current Procedural Terminology (CPT) handbook (see Appendix A);
2. hematology profiles and component tests normally included as part of a hematology profile for hematology procedure codes listed in the CPT handbook (see Appendix A); and
3. urinalysis and component tests listed in the CPT handbook (see Appendix A).

We then performed computer applications to extract all records for the same individual for the same date of service with HCFA's Common Procedure Coding System (HCPCS) line item charges for:

1. more than one chemistry panel, a chemistry panel and at least one individual panel test, or two or more panel tests;
2. more than one automated hematology profile under different profile codes, more than one unit of the same profile, a component normally included as part of a profile in addition to the profile, or hematology indices and a profile; and
3. a complete urinalysis test and microscopy, a urinalysis without microscopy, or a microscopy only.

This extract resulted in a sample population totaling \$727,660 consisting of three strata. The first strata consisted of 19,322 instances totaling \$407,490 for potentially unbundled chemistry panel tests. The second strata consisted of 21,926 instances totaling \$315,691 for potentially duplicate hematology profile tests. The third strata consisted of 1,223 instances totaling \$4,479 for urinalysis tests with potentially unbundled or duplicate tests. Each instance is a potential payment error in which the State paid providers for clinical laboratory tests (on behalf of the same beneficiary of date on the same date of service) which were billed individually instead of as part of a group, or were duplicative of each other.

On a scientific stratified selection basis, we examined 150 instances involving claims from three strata. The first stratum consisted of a randomly generated statistical sample of 50 potentially unbundled instances involving chemistry panel tests totaling \$1,105. The second stratum consisted of a randomly generated statistical sample of 50 potentially duplicate instances involving hematology profile or profile component tests totaling \$698. The third stratum consisted of a randomly generated statistical sample of 50 potentially duplicate instances involving urinalysis tests totaling \$179.

We utilized a standard scientific estimation process to quantify overpayments for unbundled chemistry panel tests and duplicate hematology profile tests, and unbundled or duplicate urinalysis tests as shown in the following schedule.

Stratum	Number of Items	Number Sampled	Examined Value	Number of Errors	Error in Sample	Estimated Recovery
Chemistry Tests	19,322	50	\$1,105	45	\$475	\$ 183,578
Hematology Tests	21,926	50	698	50	366	160,419
Urinalysis Tests	1,223	50	179	7	10	257
Totals	42,471	150	\$1,982	102	\$851	\$344,254

The results of the scientific sample of Stratum 1, chemistry tests, showed that 45 of 50 instances we reviewed represented overpayments for unbundled chemistry panel tests. Projecting the results of the statistical sample over the population using standard statistical methods, we estimate that \$183,578 paid for unbundled chemistry panel tests can be recovered. At the 90 percent confidence level, the precision of this estimate is plus or minus 16.03 percent.

The results of the scientific sample of Stratum 2, hematology tests, showed that 50 of the instances we reviewed contained duplicate payments for hematology profiles and profile component tests. Projecting the results of the statistical sample over the population using standard statistical methods, we estimate that \$160,419 in duplicate payments for hematology profile tests can be recovered. At the 90 percent confidence level, the precision of this estimate is plus or minus 6.33 percent.

The results of the scientific sample of Stratum 3, urinalysis tests, showed that 7 of the instances we reviewed represented overpayments for unbundled and duplicate urinalysis tests. Projecting the results of the statistical sample over the population using standard statistical methods, we estimate that \$257 paid for unbundled and duplicate urinalysis tests can be recovered. At the 90 percent confidence level, the precision of this estimate is plus or minus 58.13 percent.

The combined results for the three strata, showed that 102 of the 150 instances we reviewed represented overpayments for unbundled and duplicate chemistry, hematology, and urinalysis tests. Projecting the results of the statistical sample over the population using standard statistical methods, we estimate that a total of \$344,254 paid for unbundled and duplicate tests can be recovered. At the 90 percent confidence level, the precision of this estimate is plus or minus 8.87 percent.

**LISTING OF PROCEDURE CODE GROUPS INVOLVED IN THE
AUDIT SAMPLE OF UNBUNDLED CHEMISTRY SERVICES
BY FREQUENCY OF OCCURRENCE**

<u>PROCEDURE CODE COMBINATIONS 1/</u>	<u>FREQUENCY OF OCCURRENCE</u>
80002, 82947, 84478	1
80002, 80002, 80002, 80004, 80016	1
80003, 82947	1
80003, 80006, 82550, 83615	1
80004, 80016	1
80004, 80012, 82550	1
80004, 82465, 84478	1
80006, 82374	1
80006, 82565	1
80007, 80016	4
80007, 82947	1
80007, 82947, 82977, 83615, 84075, 84450	1
80009, 82977	1
80009, 82977, 84478	1
80010, 84550	1
80012, 82947, 84155, 84520	1
80016, 84460	1
80018, 82550	1
80018, 82947	1
80018, 82550, 84478	3
80018, 82977, 84478	1
80018, 82435, 84132, 84295	1
80018, 82550, 82977, 84478	1
80018, 82550, 83615, 84478	1
80019, 82550	2
80019, 84478	3
80019, 82977, 84478	3
80019, 82550, 82977, 84478	1
82465, 84478	1
82550, 84450	1
82565, 84450	1
82565, 84520	3
82947, 84132	1

1/ The groups of procedures listed below were provided to recipients on the same date by the same providers. The number of times the groups of procedures were provided to the same recipients by the same providers is shown in the frequency column. The total of the frequency column equals 45 (the number of unbundled chemistry instances in our sample that included overpayments).

**LISTING OF PROCEDURE CODE GROUPS INVOLVED IN THE
AUDIT SAMPLE OF UNBUNDLED HEMATOLOGY SERVICES
BY FREQUENCY OF OCCURRENCE**

<u>PROCEDURE CODE COMBINATIONS 1/</u>	<u>FREQUENCY OF OCCURRENCE</u>
85023, 85025	1
85023, 85029	5
85024, 85029	14
85025, 85029	28
85027, 85029	2

1/ The groups of procedures listed below were provided to recipients on the same date by the same providers. The number of times the groups of procedures were provided to the same recipients by the same providers is shown in the frequency column. The total of the frequency column equals 50 (the number of unbundled hematology instances in our sample that included overpayments).

BILL GRAVES, GOVERNOR OF THE STATE OF KANSAS



KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

ROCHELLE CHRONISTER, SECRETARY

August 28, 1995

Ms. Barbara A. Bennett
Regional Inspector General
for Audit: services, Region VII
601 East 12th Street
Room 284A
Kansas City, Missouri 64 106

Dear Ms. Bennett:

We have completed our review of the OIG draft audit report involving a review of certain clinical laboratory services provided under the Kansas Medicaid Program. Specifically you evaluated 50 claims each for chemistry, hematology and urinalysis tests performed in 1993 and 1994, and found a projected overpayment of \$344,254 due to incorrect bundling of procedures for payment.

RESPONSE TO AUDIT

The State Medicaid Manual (SMM) Section 6300 requires that a State Medicaid Program not pay more for outpatient clinical diagnostic tests than the amount Medicare recognizes for such tests. The SMM also states "the impact of the Medicare regulations on the Medicaid program is strictly with respect to the amount of payment. The applicable Medicare assignment and billing requirements are not necessarily to be incorporated into the State Medicaid Program."

The SMM goes on to state that "the Medicare carrier in a respective State will provide magnetic tapes of its fee schedules to the State agency". There is no requirement that the Medicare carrier provide the state with the system logic relating to the bundling of procedures. (See attachment A)

It is therefore our position that the scope of the OIG audit is beyond the requirements of the SMM. The OIG auditors reviewed claims to determine whether tests were appropriately grouped for payment (bundled). Grouping codes for payment purposes is a billing requirement and, thus, exceeds the scope of the federal regulations. The OIG audit contains no findings of the Kansas Medicaid Program reimbursing more for a laboratory test than Medicare's reimbursement for the same test.

8/31/95

ADDITIONAL INFORMATION

Staff also reviewed the decisions of the OIG Auditors regarding the bundling of procedures and their conclusions are outlined below. The Medicaid Program is required by HCFA to use the codes and definitions of the Health Care Common Procedures Coding System (HCPCS). The CPT Manual contains the laboratory HCPCS codes and definitions.

Chemistry Tests

Audit results: The state did not bundle chemistry tests CPT codes 82550, 82977 and 84478. As a result 45 of the 50 instances of chemistry tests reviewed contained errors: resulting in a \$183,578 projected overpayment for 1993 and 1994.

State's response: OIG found that CPT codes 82550, 82977 and 84478 should be included in chemistry panels. The 1993 and 1994 CPT books do not show these tests included in chemistry panels. (See attachment B) Based on this information, we disagree with 19 of the 45, or 42 percent of the findings.

Hematology Profiles

Audit results: The state did not bundle CPT code 85029 with codes 85023, 85024, 85025 and 85027 in 49 of the 50 claims reviewed, resulting in a \$160,419 projected overpayment for 1993 and 1994.

State's response: The description in the CPT book indicates that procedure code 85029 is for "additional indices" meaning it is in addition to the usual indices of 85023 through 85027 and as such, serves as a guide to more specific tests and should be allowed. (See attachment C). Based on this information we dispute 100% of the findings.

Urinalysis Tests

Audit results: Seven of the 50 claims reviewed involved billings for urinalysis without microscopic examination, CPT codes 81002 (non-automated) and S 1003 (automated) on the same day. These duplicate payments resulted in a projected overpayment of \$257 during 1993 and 1994.

State's response: We agree with these determinations.

RESPONSE TO RECOMMENDATIONS

(1) Install edits to detect bundling errors and billings which contain duplicative tests. We estimate that the State could save \$172,127 (Federal share \$101,383) annually or about \$860,635 over a 5-year period by implementing bundling and duplicate edit procedures.

The Kansas Medicaid Program installed the GMIS Claim Check software in 1995 to detect bundling errors and duplicate billings. Approximately \$32,000 per month is being saved.

The OIG's office studied the results of this software a few years ago and recommended its usage by states and Medicare carriers. It is interesting to note that the GMIS software follows the CPT guidelines for bundling the hematology and chemistry laboratory procedures reviewed in this audit, and, thus, is not in concurrence with this audit's findings.

(2) Issue instructions and/or reminders to providers concerning bundling requirements.

Providers were reminded concerning bundling requirements when the GMIS Claim Check software was installed.

(3) Identify and recover the 1993 and 1994 overpayments to each provider for unbundled clinical laboratory services. Based on our audit, we estimate \$344,254 should be recovered for calendar years 1993 and 1994.

We acknowledge a potential estimated overpayment of \$77,359.00. Because this overpayment is projected from the review of a sample of 1993 and 1994 claims, it would require the individual review of all physicians, independent laboratory and hospital providers who performed outpatient clinical diagnostic laboratory tests in 1993 and 1994 in order to determine an amount to be recovered from each provider. Due to the small amount of the overpayment, the age of the claims, and the work involved in determining the amount to recover it would not be cost effective to recover the overpayment.

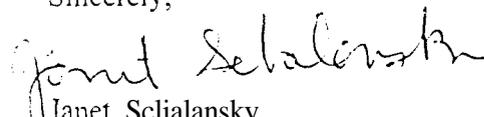
(3) Return the Federal share of the overpayments to HCFA as the overpayments are recovered.

See the answer to recommendation number 3.

Although we have responded to the findings of this OIG Audit, I want to restate that it is our position the OIG Audit goes beyond the requirements set forth in the State Medicaid Manual.

If you have questions regarding the information contained in this letter please contact Sandra Hazlett at 913 296-3981.

Sincerely,


Janet Schialansky
Deputy Secretary

JS:SCH:dct

cc: Jim Nash

09-86

PAYMENT FOR SERVICES

6300.2

6300. PAYMENT FOR OUTPATIENT CLINICAL DIAGNOSTIC LABORATORY TESTS FOR CALENDAR QUARTERS BEGINNING ON OR AFTER OCTOBER 1, 1984.

6300.1. Introduction.-Pursuant to §2303 of the Deficit Reduction Act of 1984 for services rendered to Medicare beneficiaries on or after July 1, 1984, clinical diagnostic laboratory tests performed in a physician's office, by an independent laboratory, or by a hospital laboratory for its outpatients are reimbursed on the basis of fee schedules. These fee schedules have been established on the Medicare carrier's service area (not exceeding a statewide basis). The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires national limitation amounts to be applied to the Medicare payments for outpatient clinical diagnostic laboratory services.

For services rendered on or after July 1, 1986, the national limitation amount is 115 percent of the median of all the fee schedules established for a test for each laboratory setting (i.e., separately calculated for 60 and 62 percent fee schedules).

Effective with calendar quarters beginning on or after October 1, 1984 (for services rendered on or after July 1, 1984), Federal matching funds will not be available to the extent a State pays more for outpatient clinical diagnostic laboratory tests performed by a physician, independent laboratory, or hospital than the amount Medicare recognizes for such tests. If a Medicare fee has not been established for a particular test reimbursed by Medicaid, no such limitation applies to the test. If a State agency has a buy-in arrangement with Part B of the Medicare program, it should ensure that the combined amounts of the Medicaid payment and the Medicare payment do not exceed the allowable Medicare fee or national limitation amount.

For services rendered on or after July 1, 1984, a nominal fee may be allowed under Medicare for separate charges made by physicians, independent laboratories; or hospital laboratories for drawing or collecting specimens. (See 56300.3.)

These guidelines are designed to provide assistance to the State Medicaid agencies in implementing, where applicable, the limitations of the Medicare fee schedules and the specimen collection fees into payment procedures. The impact of the Medicare regulations on the Medicaid program is strictly with respect to the amount of payment. The applicable Medicare assignment and billing requirements are not necessarily to be incorporated into the State Medicaid program. The establishment and use of (1) fee schedules for payment of clinical diagnostic laboratory tests and (2) nominal fees for specimen collection are discussed. The treatment of anatomic pathology services is provided. Reimbursement options available to States are also described.

6300.2. Fee Schedules for Outpatient Clinical Laboratory Tests.-Outpatient clinical diagnostic laboratory tests encompass tests performed in a physician's office, by an independent laboratory, or by a hospital laboratory for its outpatients. Medicaid reimbursement for clinical diagnostic laboratory tests may not exceed the amount that Medicare recognizes for such tests.

A. Application.-Each Medicare carrier in a respective State will provide magnetic tapes of its fee schedules to the State agency. (See §6300.2.D.)

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C. Clinical Diagnostic Laboratory Services.—For purposes of the fee schedule, clinical diagnostic laboratory services include laboratory tests listed in codes 80002-89399 of the Current Procedural Terminology Fourth Edition, 1986 printing, (CPT-4). Certain tests, however, are required to be performed by a physician and are therefore exempt from the fee schedule. These tests include:

80500-80502	Clinical pathology consultation
85095-85109	Codes dealing with bone marrow smears and biopsies
86077-86079	Blood bank services
88000-88125	Certain cytopathology services
88160-88199	Certain cytopathology services
88300-88399	Surgical pathology services

Some CPT-4 codes in the 80000 series are not clinical diagnostic laboratory tests. Such codes include codes for blood products such as whole blood, various red blood cell products, platelets, plasma and cryoprecipitates. Other codes for tests primarily associated with the provision of blood products are also not considered to be clinical diagnostic tests. These codes include the various blood crossmatching techniques.

The following codes are never subject to fee schedule limitations:

86012	86068
86013	86069
86016436019	86072-86076
86024	86100
86026	86120
86028	86128
86034	86265-86267

The following codes should not be subject to fee schedule limitations when they are submitted for payment on the same bill with charges for blood products:

86011	86082
86014	86090
86031-86033	86095
86035	86096
86080	86105

If no blood product is provided and billed on the same claim, these codes are subject to the fee schedule.

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PAYMENT FOR SERVICES

Attachment A
State Medicaid Manual
6300.5

State agencies may consult with regional offices concerning the implementation of the fee schedule and specimen collection provisions.

Presently, Medicare will recognize Up to \$3 for a specimen collection whether or not the specimens are referred to physicians or other laboratories for testing. This fee will not be paid to anyone who has not actually extracted the specimen from the patient. Only one collection fee may be allowed for each patient encounter, regardless of the number of specimens drawn. A specimen collection fee may be allowed only in circumstances including, but not limited to: (1) drawing a blood sample through venipuncture (i.e., inserting into a vein a needle with syringe or vacutainer to draw the specimen) or (2) collecting a urine sample by catheterization. A specimen collection fee is not allowed for blood samples where the cost of collecting the sample is minimal, such as a throat culture or routine capillary puncture for clotting or bleeding time.

Medicare will recognize a specimen collection fee when it is medically necessary for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient. The technician must personally draw the specimen, i.e., venipuncture or urine sample by catheterization. A specimen collection fee should not be allowed the visiting technician where a patient in a facility is not confined to the facility or the facility has on duty personnel qualified to perform the specimen collection. A specimen collection fee not exceeding \$5 may be allowed in drawing a specimen from one patient in a nursing home or a homebound patient. An amount not exceeding \$3 per patient may be allowed when specimens are drawn from more than one patient during the same nursing home visit. Exceptions to the above rules may be permitted under certain circumstances, such as allowing a travel expense in addition to the specimen collection fee where the patient is confined to a nursing home in a distant rural area.

When independent (free-standing) or hospital-based ESRD facilities are paid on a composite rate basis, no specimen fees should be paid since specimen collection costs are included in the composite rate except for Method II home dialysis patients. Where the State permits reimbursement under Method II, a separate specimen collection fee may be paid if the specimen is drawn by an ESRD facility or laboratory. The specimen collection fee is not allowed when a physician or one of a physician's employees draws a specimen from a dialysis patient because it is included in the Monthly Capitation Payment.

6300.4 Who Can Bill and Receive Payment for Clinical Laboratory Tests.-Payment for clinical laboratory tests subject to the fee schedule may only be made to the person or entity performing or supervising the performance of the tests. The general rules of 42 C F R 447.10(g)(2), (3), and (4) on reassignment are followed for clinical diagnostic laboratory tests as for all other services.

6300.5 Competitive Bidding or Other Arrangements.-42 CFR 431.54(d) allows a Medicaid agency to enter into arrangements to purchase laboratory services. Section 1903(i)(7) of the Act requires that States may not pay more in the aggregate for clinical diagnostic laboratory tests than the amount that would be paid for the tests under Medicare fee schedule. If a Medicaid agency, therefore, enters into arrangements to purchase laboratory services, the total payment for the clinical diagnostic laboratory tests may not exceed the amount recognized by Medicare.

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PAYMENT FOR SERVICES

6300.6(Cont.)

<u>Name</u>	<u>Positions</u>	<u>Picture</u>
HCPCS	5	X(5)
60% Fee Schedule*	7	9(5)V99
62% Fee Schedule*	7	9(5)V99

DETAIL RECORD

<u>field NO.</u>	<u>Field Name</u>	<u>Size</u>	<u>Picture</u>	<u>Field Specification</u>
1	HCPCS	5	X(5)	L
2	Filler	2	x x	L
3	Filler	2	XX	L
4	50% Fee Schedule *	7	9(5)V99	R
5	62% Fee Schedule *	7	9(5)V99	R
6	Filler	10	X(10)	L
7	Carrier #	5	X(5)	L
8	Filler	2	XX	
9	Carrier Name	20	x(20)	L

*Adjusted for national limitation amounts.

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Attachment B
Chemistry Tests

PATHOLOGY AND LABORATORY

Procedures

Automated, Multichannel Tests

The following list contains those tests that can be and are frequently done as groups and combinations ("profiles") on automated multichannel equipment. For any combination of tests among those listed immediately below, use the appropriate number 80002-80019. Groups of the tests listed here are distinguished from multiple tests performed individually for immediate or "stat" reporting. (For handling of specimen, see 99000 and 99001)

Alanine aminotransferase (ALT, SGPT)

Albumin

Aspartate aminotransferase (AST, SGOT)

Bilirubin, direct

Bilirubin, total

Calcium

Carbon dioxide content

Chloride

Cholesterol

Creatinine

Glucose

Lactate dehydrogenase (LD)

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Attachment B
Chemistry Tests

PATHOLOGY AND LABORATORY

Procedures

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Bilirubin, direct

Bilirubin, total

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Chloride

Cholesterol

Creatinine

Glucose

Lactate dehydrogenase (LD)

85024—85102 Hematology and Coagulation

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Attachment C
Hematology Profiles

- 85024 hemogram and platelet count, automated, and automated partial differential WBC count (CBC)
- 85025 hemogram and platelet count, automated, and automated complete differential WBC count (CBC)
- 85027 hemogram and platelet count, automated
(85028 has been deleted. To report, use 85023-85025)
- 85029 Additional automated hemogram indices (eg, red cell distribution width (RDW), mean platelet volume (MPV), red blood cell histogram, platelet histogram, white blood cell histogram); one to three indices
- 85030 four or more indices
- 85031 Blood count; hemogram, manual, complete CBC (RBC, WBC, Hgb, Hct, differential and indices)
- 85041 red blood cell (RBC) only
(See also 85021-85031, 89050)
- 85044 reticulocyte count, manual
- 85045 reticulocyte count, flow cytometry
- 85048 white blood cell (WBC)
(See also 85021-85031)
- 85060 Blood smear, peripheral, interpretation by physician with written report
- ▲ 85095 Bone marrow; aspiration only
(85096 has been deleted. For interpretation of smear, use 85097; for cell block interpretation, see 88365)
- 85097 smear interpretation only, with or without differential cell count
(85100 has been deleted. To report, use 85095 and 85097)
(85101 has been deleted. For aspiration, see 85095)
(For special stains, see 85540, 88312, 88313)
- 85102 Bone marrow biopsy, needle or trocar
(For bone biopsy, use 20220)

85014—85095 Hematology and Coagulation

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Attachment C
Hematology
Profiles

- 85014 other than erythrocytosis
- 85018 hemoglobin
(For other hemoglobin determination, see 83020-83069)
- 85021 hemogram, automated (RBC, WBC, Hgb, Hct and indices only)
- 85022 hemogram, automated, and manual differential WBC count (CBC)
- 85023 hemogram and platelet count, automated, and manual differential WBC count (CBC)
- 85024 hemogram and platelet count, automated, and automated partial differential WBC count (CBC)
- 85025 hemogram and platelet count, automated, and automated complete differential WBC count (CBC)
- 85027 hemogram and platelet count, automated
(85028 has been deleted. To report, use 85023-85025)
- 85029 Additional automated hemogram indices (eg, red cell distribution width (RDW), mean platelet volume (MPV), red blood cell histogram, platelet histogram, white blood cell histogram); one to three indices
- 85030 four of more indices
- 85031 Blood count; hemogram, manual, complete CBC (RBC, WBC, Hgb, Hct, differential and indices)
- 85041 red blood cell (RBC) only
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- 85044 reticulocyte count, manual
- 85045 reticulocyte count, flow cytometry
- 85048 white blood cell (WBC)
(See also 85021-85031)
- 85060 Blood smear, peripheral, interpretation by physician with written report
- 85095 Bone marrow: aspiration only



80701 - 99199
Medicine

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Appendices